Baltimore City Medicare Part D Surveillance and Response Initiative

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EXECUTIVE SUMMARY

On December 8, 2003, President Bush signed into law the Medicare Modernization Act. Included in that legislation was the Medicare prescription drug program known as Medicare Part D, a program intended to provide prescription assistance to low-income and elderly Americans. Although many Americans would eventually benefit from prescription assistance in the event of illness, the scope and complexity of the switch to Part D were unprecedented.

The federally mandated transition to Medicare Part D was scheduled to take place on January 1, 2006. In advance of the transition, federal, state, and city officials supported an array of activities to reach out to affected patients.

Yet as the transition date approached, Baltimore City officials recognized that the abrupt switch in prescription coverage could still limit access to medications for vulnerable, low-income disabled or elderly residents. To address this concern, the Health Department designed the Baltimore City Medicare Part D Surveillance and Response Initiative in close collaboration with the Commission on Aging and Retirement Education and city pharmacies.

Under this initiative, Baltimore City:

- Established a **24-hour surveillance program** using faxes and the city's 311 line so that pharmacies could report problems experienced by city residents with Medicare Part D;

- Created an **electronic follow-up database** to ensure that residents identified with problems would be contacted by caseworkers from the city's Commission on Aging and Retirement Education;

- Provided for **immediate intervention** to prevent Baltimore's poorest and most vulnerable residents from forgoing essential medications during the transition, including the establishment of a $50,000 reserve fund for medications;

- Prepared to **advocate** for city residents with Medicare drug plans that failed to meet expectations on coverage; and

- Built upon its existing **biosurveillance** system to monitor for changes in Emergency Department use among seniors.

This report reviews the initiative's record and evaluation to date. It finds:

- **Pharmacists made 163 reports of patients requiring assistance with the Part D transition.** These reports came from 55 different pharmacies in 20 zip codes. 73% of pharmacists and staff surveyed were aware of the city's efforts and possessed at least an adequate knowledge of how and when to use the initiative.

- **Pharmacists reported major problems with the transition to Medicare Part D.** Common problems included overcharging low-income residents (67 reports), failure to automatically transfer low-income residents (50 reports), and problems with the move from state pharmacy assistance (15 reports). Pharmacy reports of problems with Medicare Part D have persisted into July 2006.

- **Baltimore City has authorized approximately $15,000 in prescription drugs for 60 residents to ensure continued access to medications.** The most common types of drugs covered were antihypertensives (48), psychiatric medications (22), anti-cholesterol drugs (18), and diabetic drugs (15). The city also faxed every pharmacy nine times to provide advice on how to navigate Medicare Part D on behalf of Baltimore residents.

- **City systems handled the reports and follow-up efficiently.** After an early review identified and fixed problems, all pharmacy calls to 311 were answered immediately or within minutes by Health Department staff. The electronic follow-up database permitted quick transfer of information from the Health Department to the Aging Commission. From there, Aging Commission case managers contacted 90% of patients reported by pharmacies with 72 hours to provide follow-up assistance with Medicare Part D enrollment. Fewer than 5% of pharmacy staff surveyed reported that logistical issues kept them from reporting cases.

- **No increase was noted in the number of seniors with high blood sugar at a major Baltimore emergency department.** This finding supports the conclusion that seniors generally had preserved access to medications over the initial months of transition.

The Baltimore City Medicare Part D Surveillance and Response Initiative has provided important support to vulnerable city residents and provides lessons for future emergency preparedness efforts.

I. INTRODUCTION

On December 8, 2003, President Bush signed into law the Medicare Modernization Act. Included in that legislation was the Medicare prescription drug program known as Medicare Part D, a program intended to provide prescription assistance to low-income and elderly Americans.

On the day of its passage, the White House lauded the plan as "a victory for all of America's seniors," where "seniors in the greatest need will have the greatest help under the modernized Medicare system."[1] The speaker of the House of Representatives, Dennis Hastert, stated that the program offered a "historic opportunity to select a Medicare prescription drug plan that may save them more than 50 percent on their prescription drugs." The President stated that "with this law, we're giving older Americans better choices and more control over their health care."

The plan would not take effect until January 1, 2006. As the date grew closer, significant concerns were raised about the impact that the transition would have on seniors and the disabled. Although many Americans would eventually benefit from prescription assistance in the event of illness, the scope, abruptness, and complexity of the switch to Part D were unprecedented.

Under Medicare Part D, individuals could choose among dozens of private insurers who are competing with one another on the basis of drug selection, pharmacy network, and price. This complexity worried public health officials at the national and local levels. In December 2005, the U.S. Government Accountability Office issued a cautionary report suggesting that "the complex process for transitioning dual-eligible beneficiaries on a single day with no overlap could create difficulties ensuring that prescription for some members of this vulnerable population are filled."[2]

II. BALTIMORE CITY MEDICARE PART D SURVEILLANCE AND RESPONSE INITIATIVE

Prior to the transition date, Baltimore City officials recognized that an abrupt switch in prescription coverage could limit access to medications for many disabled or elderly residents with limited resources and poor health. Federal, state, and local officials had conducted numerous seminars and outreach activities to enroll residents in the private drug plans that provide the Part D benefit.[3,4,5] Nonetheless, city officials were concerned that these efforts would not reach all of the thousands of City

residents who would move to Part D. Jointly with City pharmacists and the Commission on Aging and Retirement Education (CARE), the Baltimore City Health Department developed the Medicare Part D Surveillance and Response Initiative.

A. Identification of At-Risk Populations

The initiative identified three groups in Baltimore City to be especially at risk:

- Approximately 20,000 residents dually enrolled in Medicare and Medicaid were to be automatically transferred from their Medicaid drug benefits to Part D.[6] When compared to other Americans on Medicare, these "dual eligibles" are substantially more likely to be elderly, impoverished and poorly educated. This population additionally has a higher incidence of chronic disabilities, mental illness, and impairments requiring nursing home care. Recognizing the vulnerability of this population, the GAO had identified three potential problems that these dual eligibles may experience during the process of switching drug coverage from Medicaid to Medicare.

  - Potential loss of coverage "due to potential inaccuracies in state and federal data."
  - Potential loss of coverage if dual eligibles had only recently become eligible for Medicaid.
  - Problems in obtaining certain prescription drugs or obtaining service from their customary pharmacies.[ii].

- More than 8,000 seniors in Baltimore City were receiving state-financed pharmacy assistance through the Maryland Senior Prescription Drug Assistance Program or the Maryland Pharmacy Assistance Program.[7] At the close of 2005, these state programs for seniors were to end, and all participants were to be transferred to Part D. For this population, anticipated difficulties included enrollment and identification of plans that appropriately cover their preferred medications.

- An additional group of approximately 77,000 seniors in Baltimore City were eligible for voluntary enrollment in Medicare Part D. It was anticipated that many of these seniors, as city retirees, would not enroll for the new program because they would continue to receive drug coverage through their employers. However, those who did elect to participate would be subject to the same difficulties with enrollment and choices of medications, pharmacies or drug plans.

B. Initiative Plan

To develop the initiative's plan, the Health Department and CARE met with representatives from all chain pharmacies in Baltimore City, the City independent pharmacy collaborative, and the Maryland Pharmacy Association to clarify goals and operational details of the referral network.

The initiative was designed both to help City residents experiencing problems with Part D and to provide a framework for further City preparedness efforts. A key goal was to test the capacity of Baltimore City agencies to quickly assess a potential public health crisis, gather information, coordinate multiple agencies, and respond effectively. It was hoped that the effort would inform preparations for natural disasters, outbreaks of infectious disease, and bioterrorism events.

Under this initiative, Baltimore City:

- Established a 24-hour surveillance program based on a network of 98 pharmacies across Baltimore City in order to identify problems experienced by city residents with Medicare Part D. This program utilized the city's 311 system, electronic faxes, and Internet capability.

- Created an electronic follow-up database in collaboration with the Commission on Aging and Retirement Education to ensure that residents identified with problems would be contacted by caseworkers from the Commission on Aging and Retirement Education, who provided assistance with enrolling patients in drug plans within 72 hours.

- Provided immediate intervention to prevent Baltimore's poorest and most vulnerable residents from forgoing essential medications during the transition. Aid included real-time advice to pharmacists on Part D billing procedures, and use of a $50,000 reserve fund for medications when all other options were exhausted.

- Advocated for city residents with Medicare drug plans that failed to meet expectations on coverage. Advocacy letters were sent to executives of private drug plans for each instance that a Baltimore City resident was overcharged or dropped from coverage. A copy of each of these letters was also sent to Medicare.

- Built upon its existing biosurveillance system to monitor for changes in Emergency Department use among seniors. Hyperglycemia was an

initial finding of poor access to medications among evacuees of Hurricane Katrina. The team tracked hyperglycemia among patients over 65 years of age presenting to a major city emergency department, and then compared the data to a baseline taken from similar timeframes in previous years.

In designing this strategy and throughout its initial implementation stages, the Health Department consulted with officials at the Department of Health and Mental Hygiene and the federal Center for Medicare and Medicaid Services. Both agencies supplied special phone numbers and transition resources that the Health Department disseminated to pharmacists. The Department of Health and Mental Hygiene also opened a call line for those residents formerly covered by the Maryland Pharmacy Assistance Program who were transitioned to a Part D plan.

Information on the initiative was distributed by fax, email and phone, as well as personal visits to 58 pharmacies. The Baltimore City Medicare Part D Surveillance and Response Initiative was announced on December 21, 2005, and implemented on January 1, 2006.

III. METHODOLOGY

The evaluation of the Baltimore City Medicare Part D Surveillance and Response Initiative has four components: descriptive measures, a performance assessment, phone survey of pharmacists, and a review of data from a large city emergency department.

A. Descriptive measures

These measures included the number of contacts between pharmacies and the surveillance system, the types of problems reported by patients, the types of drugs that patients reported having trouble obtaining, advocacy efforts on behalf of patients, and the outcomes of these efforts.

B. Performance Assessment

A performance assessment was conducted in January 2006 to assess the function of the initiative. Sources of data included:

- the 311-telephone system;
- hospital ER biosurveillance reports;
- transmission reports from Baltimore City Health Department (BCHD) blast faxes;
- initial database query reports; and

- manual review of the Surveillance and Response Initiative database.

Performance markers in this assessment included:

- percentage of successful warm transfers from the 311 line to the Health Department;
- fax transmission rates to pharmacies;
- percentage of referrals receiving follow-up from the Commission on Aging and Retirement Education within three business days; and
- numbers of prescriptions authorized by the Health Department.

C. Survey of Pharmacists and Staff

To assess the success of the initiative in reaching pharmacies across Baltimore City, a phone survey was conducted. The survey assessed:

- pharmacy staff awareness of the program;
- efficiency of methods of communication between pharmacies and city government; and
- motivating factors contributing to participation or lack of participation in the program.

To achieve a representative sample of pharmacies across Baltimore City, pharmacies were first stratified into "responders" and "non-responders" and then randomized. Using both subsets, a group of 50 pharmacies was randomly selected and a pharmacist or technician was asked to participate in the voluntary survey. The Institutional Review Board of the University of Maryland School of Medicine exempted the survey from review.

D. Review of Emergency Department Data

The number of seniors presenting to a major area emergency department with hyperglycemia (blood glucose >300 mg/dl) was tracked and compared to data from corresponding months in the previous year.

IV. RESULTS

A. Descriptive Measures

1. The Baltimore City Health Department successfully faxed all city pharmacies 9 times with information and advice.

The faxes offered key strategies in how to successfully enroll patients in Part D plans, such as 1-800 numbers and instructions on how to access a backup pharmacy plan. Pharmacists informally reported back that the advice was very helpful in working through some of the early problems with Medicare Part D.

2. Pharmacists made 163 reports of patients requiring assistance to the surveillance system.

To report problems with Medicare Part D, pharmacists had the option of either directly contacting the Health Department by fax or email, or calling the city 311 call center to be transferred to a dedicated 24 hour call line staffed by the Health Department. The duty officer for the call line was then able to offer direct advice to pharmacists regarding Part D billing procedures or to authorize funding for prescription medications when no other options were available. Forty-one percent of reports were received in January, and reporting has persisted through July.

Between January 1, 2006 and June 30, 2006, the Health Department received a total of 163 reports (69 faxes, 85 phone calls, 9 emails). These reports came from 55 different pharmacies in 20 zip codes.

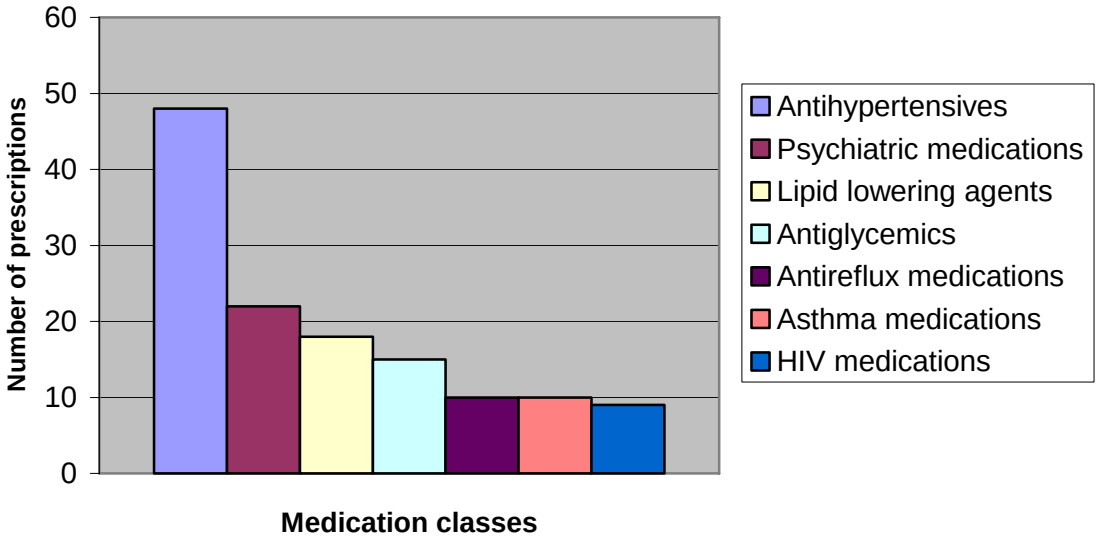
In response to these calls and faxes, the Health Department provided advice to pharmacists, which on many occasions was successful in resolving the patient's problems with Medicare Part D.

3. The Health Department has authorized 215 prescriptions for 60 patients, at a cost of approximately $15,000.

When all alternatives had been explored, Health Department on-call personnel authorized 215 prescriptions for 60 patients, at a cost of approximately $15,000.

While 40% of the total spending occurred in January, the Health Department has continued to receive requests for financial assistance, authorizing funding for prescription medications totaling $1084.83 in the first two weeks of July alone. Of the total prescriptions authorized, blood pressure lowering agents were the most frequently requested class of medication; other commonly encountered classes included medications for psychiatric disorders, diabetes, HIV and high cholesterol (Figure 1).

Figure 1: Classes of authorized prescription medications



4. Baltimore residents have faced three main problems with Medicare Part D.

a) Overcharging of low-income residents

Sixty-seven reports involve patients previously on Medicaid or state pharmacy assistance who should not be charged co-payments of more than $5 per prescription. Some private drug plans, however, have instead charged deductibles and significant co-payments that can total hundreds of dollars. While the Center for Medicare & Medicaid Services advises pharmacists to call the private plan to rectify the situation, many pharmacists have reported that contacting these plans can be extremely difficult and time consuming. For example:

- Baltimore City received a report of an 80-year-old man who was being substantially overcharged for eight essential medications, including medications for blood pressure. The Baltimore City pharmacy officer on call authorized $168.28 to cover the medications. A case manager from the city Commission on Aging and Retirement Education followed up with the patient to ensure he is properly enrolled.

- Baltimore City received a report from a pharmacist that 11 low-income patients at a nursing home were being charged excessive co-payments by the same Medicare drug plan. The pharmacist provided a few days of medication, and an advocacy letter was written by the health department to the drug plan to request their immediate attention to the problem. The drug plan responded to the letter, called the pharmacist, and fixed the co-payment problem.

b) No coverage for low-income residents.

Fifty reports involve patients who previously had drug coverage through the Medicaid program, but were not automatically assigned as planned into Medicare Part D. For these individuals, the Center for Medicare & Medicaid Services established a complicated pharmacy-based enrollment process that could provide emergency access to a 14-day supply of medications. Many pharmacies have reported failures in navigating this process and moreover, no definitive solution was established to provide for these patients once the 14-day supply was exhausted. For example:

- Baltimore City received a report of an 84-year-old woman who had been dropped in the transition of her drug coverage from Medicaid to Medicare Part D. She urgently needed medication for hypothyroidism, asthma, and cardiac arrhythmia. The Baltimore City pharmacy officer on call authorized $234.54 for her medications. The Commission on Aging and Retirement Education then followed up and scheduled her for an enrollment session at a local senior center.

- Baltimore City received a report of an 85-year old woman who was enrolled in both the Medicaid and Medicare program. The pharmacist was unable to fill her glaucoma medications. The claim submission failed for lack of enrollment information. The Baltimore City pharmacy officer on call authorized $244.29 to purchase her meds and referred her to the Commission on Aging to ensure she has drug coverage. Her coverage problems were then addressed.

c) Problems with the transition from state pharmacy assistance

The Health Department has received 15 reports of patients formerly covered by the Maryland Pharmacy Assistance Program (MPAP), who were left without any coverage at all when the planned automatic transition to

Medicare Part D did not occur. The federal emergency 14-day supply is not available to these individuals. For example:

- Baltimore City received a report of an 80-year old woman who had been receiving prescription aid from MPAP. The patient was released from the hospital on January 9, 2006, and discovered that she was unable to fill her prescription medications. The pharmacist provided 30 days of medications, and the Commission on Aging and Retirement Education assisted the patient in enrolling in a drug plan.

- Baltimore City received a report of a 41-year old woman who had received a letter confirming that her coverage had been switched from MPAP to Part D. When she attempted to fill her prescriptions, however, the drug plan informed the pharmacy that they had no record of her enrollment. The Health Department authorized $305.45 to pay for her prescriptions, and the Commission on Aging and Retirement Education provided assistance in verifying her enrollment in the drug plan.

Two instances each were reported of drug plans not covering specific medications or specific pharmacies. These issues both pose significant obstacles to patients whose limited resources, mobility, or medical condition may make it difficult to change pharmacies or medications.

5. The Health Department advocated on behalf of 36 Baltimore residents by writing letters to drug plans.

Based on the pharmacy reports, the Commissioner of Health in Baltimore City sent advocacy letters to the leadership of twelve different Medicare Part D plans on behalf of 36 Baltimore residents. These letters explain the problems experienced by pharmacists and request immediate attention by the plan. All twelve of the plans promptly contacted the Health Department for further details on the cases and followed up with the local pharmacist, with known resolution of several problems.

6. The Medicare Part D Surveillance and Response Initiative has cost approximately $56,000 in addition to regular staff time and expertise.

The costs of the Medicare Part D Initiative have been in staff salary, electronic infrastructure, and medications. Anticipating an increased caseload created by the Medicare Part D Initiative, the Health Department paid $40,000.00 toward the salary of extra caseworkers at the Commission on Aging and Retirement Education. The Health Department

authorized 215 prescriptions for 60 patients, at a cost of approximately $15,000. Operations costs included approximately $400.00 for electronic fax capacity, $75.00 for the frequent blast faxes to City pharmacies, and $150.00 for cell phones dedicated to the project. Other costs include substantial staff time from the Medicare Part D team in both the Health Department and Commission on Aging and Retirement Education, including time in December and January on the design and implementation of the database and time for 24-hour coverage and database entry.

B. Performance Assessment

Two weeks after the initiation of the program, a performance assessment revealed that there were five failures in transferring pharmacy calls from the 311 call center to the Health Department by the end of the second week. Analysis of the failed transfers showed that they typically occurred when the pharmacy officer was busy with another caller. In order to increase the percentage of successful transfers, the Health Department developed an email back-up system. In the event that warm transfer of a call was unsuccessful (after three attempts), the 311 system automatically generated an email with pharmacy contact information to the pharmacy officer on call, who then immediately called the pharmacist. Subsequent follow-up demonstrated that the email system in conjunction with the 311 call center allowed 100% of requests for assistance to be immediately received by Health Department staff.

Initial data also revealed:

- 95% of 311 calls were transferred to the Health Department duty phone within 5 minutes;

- Fax transmission rates indicated that between 92% and 97% of the total 98 Baltimore pharmacies were receiving weekly blast faxes from the health department; and

- Of the 80 filed reports, the Health Department provided direct assistance in solving the Part D problem to pharmacists in 35 cases (44%), and provided financial intervention in 14 cases (18%).

While the Commission on Aging and Retirement Education had contacted 100% of referrals, the assessment revealed that only 75% of those contacts had taken place within the pre-specified objective of three business days.

In response to these findings, the administrators from Health and Commission on Aging and Retirement Education met to address prompt outreach efforts. The Health Department provided $40,000 to fund two additional Commission on Aging and Retirement Education caseworkers to help manage the large volume of cases. Subsequent data showed that 90% of cases received follow-up within 72 hours.

C. Pharmacy Survey

1. 73% of pharmacy respondents reported awareness of the Medicare Part D initiative.

Of the 50 pharmacies randomly selected, staff at 33 (66%) responded to the survey. The majority of the responders (73%) were aware of the Medicare Part D Surveillance and Response Initiative, and of those, all reported possessing an adequate to comprehensive knowledge of how and when to use the initiative.

2. 67% of pharmacy respondents reported faxing to be the most effective method of communication.

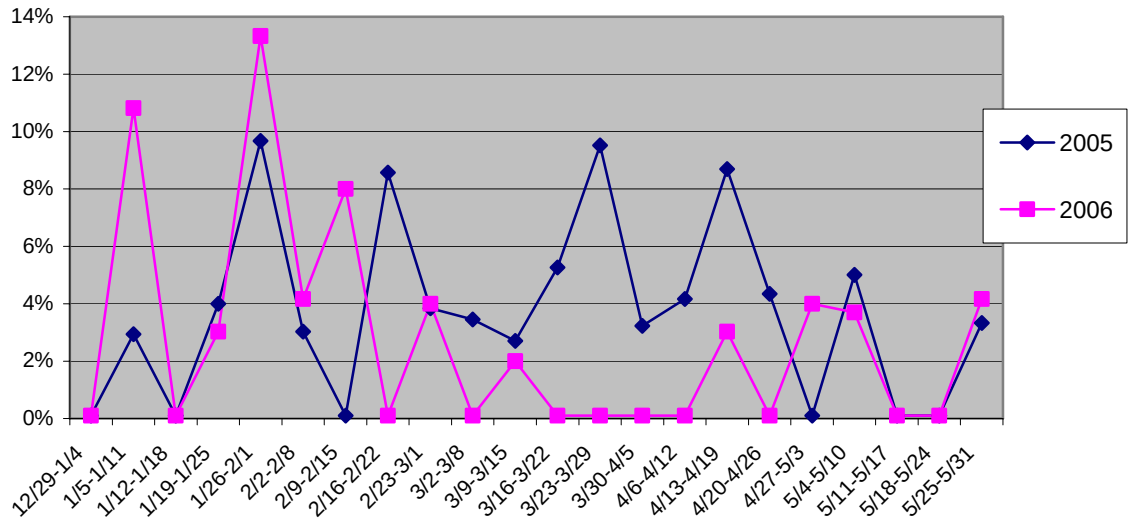
When asked about the most appropriate method of communication between pharmacies and the Baltimore City Health Department, pharmacists and pharmacy staff stated that faxing was by far the most useful means of dispersing information about an ongoing program, but that phone calls more effectively communicate information in the event of a public health emergency.

Additional methods of direct communication by the Health Department, including email and personal visitation of pharmacies, were reported to be largely ineffective tools. Survey respondents were also polled about alternate sources of information on the citywide program. For this initiative, 63% of pharmacies reported that they did receive information from their district offices, but only a single respondent reported receiving information from the Maryland Pharmacists Association.

3. Few pharmacies reported barriers to participating in the Baltimore city initiative.

Fewer than 5% of responding surveys reported that they did not participate in the initiative because of insufficient time to complete the paperwork or perceptions that the process was too complicated.

Figure 2: Percentage of ER patients over 65 years of age with glucose levels >300



D. Emergency Department Data

In comparison to 2005 data, no consistent trend was evident in the numbers of seniors presenting to the emergency department with hyperglycemia. This lack of increase in hyperglycemic presentations supports the conclusion that seniors had preserved access to medications over the initial months of transition (Figure 2).

V. CONCLUSIONS

A. Medicare Part D

Reliable access to prescribed medication is essential to an effective, functional health care system. An abrupt switch in health care insurance that affects thousands of residents across a city can jeopardize that access to medication, constituting a potential public health emergency. Medicare Part D, while providing financial protection for many city residents, isolated others without the resources to navigate a complicated system. Although initial confusion has subsided, this system will continue to provide challenges, in part because drug plan formularies, participating pharmacies, and enrollment data are constantly in flux. Medicare Part D as currently constructed guarantees a never-ending transition.

B. Baltimore Medicare Part D Surveillance and Response Initiative

Although the transition to Medicare Part D has been difficult for many vulnerable residents of Baltimore city, the initiative has successfully protected many from loss of access to essential medications. Collaboration across several city organizations enabled a rapid and effective intervention on behalf of at-risk City residents. Across the city, pharmacists were aware of the program and were able to participate when problems arose. Pharmacists made 163 reports of patients requiring assistance with the transition to Medicare Part D. The Health Department responded by spending nearly $15,000 providing prescription coverage for 60 residents without alternative options. Advocacy efforts proved effective, with drugs plans responding to requests and questions.

The initiative is still running and has been integrated into the Health Department's "duty officer" on-call system.

C. Need for Ongoing Assessment

Flexibility and capacity to modify ongoing efforts are critical aspects of a successful preparedness program. By incorporating a preliminary performance assessment in the initial surveillance and response plan, we were able to identify areas of weakness and alter them accordingly. The ability to track information through frequent database updates also facilitated rapid recognition of trends.

The next transition in Part D that will have a significant impact on access to medications is the "donut hole," a gap in medication coverage that begins when a Medicare beneficiary has reached total drug costs of $2,250. Until cumulative costs reach $5,100, these individuals will not receive any prescription assistance under the Medicare Part D plan. Some may forego or cut back on essential medications while in the donut hole. Pharmacies have been asked to report donut hole problems as part of an expanded surveillance effort.

D. Emergency Preparedness

By coordinating the resources of multiple city agencies, the Baltimore City Medicare Part D Surveillance and Response Initiative represented a citywide response to a public health need. Use of faxing and the 311 phone system proved to be a very effective communication structure. Baltimore City is now applying some of the lessons learned in the context

of rising energy costs. In the Baltimore City Energy Assistance Initiative, health professionals are reporting patients in need of energy assistance to the Health Department.

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